HHS Proposed Rules:

Establishment of Exchanges and Qualified Health Plans

Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment

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NPRM

- Released July 11, 2011
- Draft comments due by September 20, 2011
- Comments due September 28, 2011

Exchanges and Qualified Health Plans	Reinsurance, Risk Corridors, and Risk Adjustment
•General Functions and Standards of an Exchange •Eligibility and Enrollment •SHOP Functions and Enrollment •Qualified Health Plans (QHPs) and QHP Issuer Certifications and Standards	•Annual notice •Transitional reinsurance program •Temporary risk corridor program •Permanent risk adjustment program

Exchange Establishment

- States must submit to HHS an Exchange Plan
  - Meet federal standards
  - Fully operational by October 1, 2013
- Conditional approval
- Changes to Exchange Plans
- State-Federal Partnership

Governance

- Conflicts
  - The majority of board members may not have conflicts of interest
- Bylaws
- SHOP Governance

Customer Assistance Mechanisms

- Call Center
- Web portal
- Exchange calculator
- Outreach and education

Navigator Program

- Required but federal funds cannot be used
- State prescribes standards
- Must have at least 2 types of entities
- Program must be operational by the first day of the initial open enrollment period

Payment of Premiums

- Exchanges may select one or more of the following three options for individual premium collection:
  - Delegate
  - Collect and pass-through
  - Aggregate premiums

Enrollment Periods

- Initial Open Enrollment: Oct 1, 2013 – Feb 28, 2014
- Annual Open Enrollment: Oct 15 – Dec 7
- Alternate Open Enrollment: Nov 1 – Dec 15
- Special Enrollment: 60 days from triggering event
- Effective Dates of Coverage: First day of following month or second following month

Applications and Notices

- All publications must be in plain language and accessible to individuals with access issues
- A single application must be used, available online, by phone or mail, or in person
- Separate, single applications must be used for employers and employees in the SHOP

SHOP: Eligibility and Enrollment

- Must determine eligibility for employers and employees
- May choose ways for employers to offer one or more QHPs to employees
- Must establish a uniform timeline related to enrollment and rate changes
- Must allow for rolling enrollment periods for employers
- Must aggregate premiums
- Contemplates minimum participation standards

Certification and Accreditation of QHPs and QHP Issuers

Flexible  Prescriptive

- QHPs and QHP issuers must comply with certain standards
- Exchange has flexibility to certify QHPs in any manner it deems most effective
- Exchanges must accept two multi-state plans as QHPs without applying additional certification criteria
- States should establish a deadline by which issuers must be accredited

Network Adequacy

- Provider network should be “sufficient” for the area’s unique geography, demographics, and market conditions
- Must include a “sufficient” number of essential community providers
- Seeks comment on need for additional standards to evaluate network sufficiency and to ensure access in medically underserved areas

Recertifying and Decertifying QHPs

- Rule sets minimum certification requirements; allows states to impose additional requirements tailored to local market conditions.
- Suggests selection criteria a State might want to consider including:
  - Reasonableness of the QHP's cost
  - Past performance of issuer
  - Quality improvement activities
  - Enhancement of provider networks; service areas; and
  - Premium rate increases

Annual Notice of Insurance Benefits and Payment Parameters

- Rule requires each State to issue an annual notice to describe differences between State reinsurance or risk adjustment programs that differ from federal notice of benefit and payment parameters
- Notice would be issued a year in advance of the benefit year so issuers can account for any updates in their design and review of plan benefits and establish and review rates

Reinsurance, Risk Corridors and Risk Adjustment

Flexible ★ ★ Prescriptive

	Description	Oversight	Participants	Timing	Rationale	Duration
Reinsurance	Provides funding to plans that enroll highest cost individuals	States	All issuers and TPAs contribute funds	Throughout 2014-2016	Offsets high cost outliers	Temporary for 3 years (2014-2016)
Risk Corridors	Limit issuer loss (and gains)	HHS	Qualified Health Plans (QHPs)	After reinsurance and risk adjustment s 2014-2016	Protects against inaccurate rate setting	Temporary for 3 years (2014-2016)
Risk Adjustment	Transfers funds from lowest risk plans to highest risk plans	State Option in a State-Run Exchange	Individual and small group markets	After end of benefit year 2014 and subsequent years	Protects against adverse selection	Permanent

Reinsurance

Flexible — Prescriptive

- Rule requires all health insurance issuers and TPAs on behalf of self-insured group health plans to contribute to a not-for-profit reinsurance entity to support reinsurance payments to individual issuers that cover high-cost cases
  - $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016
  - Contribution rate would be nationally set as a percentage of premiums collected
  - Not intended to replace ongoing commercial reinsurance
- Additional contributions for deposit into the US Treasury's general fund ($2 billion in each of CY2014 and CY2015, $1 billion in CY 2016)
- States may either contract with an existing reinsurance entity or establish a reinsurance entity(s). Either approach must extend sufficiently to fulfill reinsurance requirements through 2016 and all follow up activities but not longer than December 31, 2018
- Several States may contract with the same reinsurance entity, but the risk pools must remain separate for each State's programs
- Detailed proposed rules on mechanics for payments into reinsurance entities and disbursements of reinsurance payments
- Rule requires the State to eliminate any State high risk pool to the extent necessary to carry out the reinsurance program. State can also elect to continue and modify its high risk pool to conform to the NPRM requirements.

Risk Corridors

- Federally administered
- Protects against uncertainty in setting rates by limiting the extent of issuer losses and gains
- An issuer of a QHP whose gains are >3% of the issuer's projects must remit charges to HHS (HHS will pay a QHP issuer that experiences losses >3% of projections)
- All QHPs that are part of the Exchange must adhere to the HHS standards. Guidelines are plan, not issuer, specific.

Risk Adjustment

Flexible  Prescriptive

- Intended to reduce or eliminate premium differences plans based solely on expectations of favorable or unfavorable risk selection
- States will assess charges to plans that experience lower than average actuarial risk and use them to make payments to plans with higher than average actuarial risk
  - Risk pools must be aggregated at the State level, even if the State utilizes regional Exchanges
  - Multiple States can contract with the same risk adjustment administrator, but the risk must be pooled at the individual State level
- All payment calculations must commence with the 2014 benefit year
- State would be required to report to HHS risk adjustment activities for each benefit year
- HHS will develop a federally-certified risk adjustment methodology, or States can use an alternate methodology if it has similar or better performance than the federal one
  - Required publication in annual notice
  - Requires HHS review and certification
- States must collect risk-related data to determine individual risk scores and validate a statistically valid sample of data from each issuer that offers at least one risk adjustment covered plan in the State
- State must provide an administrative process to appeal data validation findings

Next Steps

- Future Rulemaking on topics such as:
  - Essential health benefits and other benefit design standards
  - Cost sharing limits
  - Recognition of accreditation of QHP issuers by HHS
  - Quality standards for Exchanges and QHP issuers
- Draft comments will be considered at September 20 Board meeting